Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PLAINVIEW CHIROPRACTIC CLINIC
4909 34th STREET
LUBBOCK TX 79410-2308

Respondent Name

INSURANCE CO OF THE STATE OF PA

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-04-9405-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "[Claimant} was last seen by a Designated Doctor. Dr. Weber stated that [Claimant} has shown improvement and that the physical abilities would continue to improve performing therapeutic activities and was not at MMI until 06/30/03."

Amount in Dispute: $2353.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated June 3, 2004: "The Carrier asserts that the requestor has neglected to follow the requirements of 28 TAC §133.307(e)(2) because the request does not include either the response from the Carrier to the reconsideration request or convincing proof of the Carrier's receipt of the reconsideration request. The requestor has not included EOB's with its request for medical dispute resolution or documentation showing the carrier received its request for reconsideration."

Respondent's Supplemental Position Summary dated June 18, 2004: "**This is a fee dispute involving retrospective medical necessity**. The carrier disputes that the provider has shown that the treatment underlying the charges were medically reasonable and necessary. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines. All reductions of the disputed charges were appropriately made."

Response Submitted by: Flahive, Ogden & Latson, P.O. Box 13367, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 6, 2003 June 10, 2003 June 12, 2003 June 13, 2003 June 16, 2003 June 17, 2003	CPT Code 97112	$40.00/date	$175.00
June 9, 2003 June 10, 2003 June 12, 2003	CPT Code 97530 X 3 units	$120.00/date	$630.00

June 13, 2003 June 16, 2003 June 17, 2003			
June 9, 2003 June 13, 2003	CPT Code 97265	$50.00/date	$86.00
June 6, 2003 June 9, 2003 June 10, 2003 June 12, 2003 June 13, 2003 June 16, 2003 June 17, 2003	CPT Code 99213-MP	$55.00/date	$288.00
June 10, 2003 June 12, 2003 June 16, 2003 June 17, 2003	CPT Code 97250	$50.00/date	$172.00
June 25, 2003	CPT Code 99455-L1-WP	$600.00	$318.00
June 25, 2003	CPT code 99090	$108.00	$0.00
TOTAL DUE			$1669.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 TexReg 4047, requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
2. Texas Labor Code §413.011 requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.
3. 28 Texas Administrative Code §134.201, titled *Medical Fee Guideline for Medical Treatments and Services Provided Under the Texas Workers' Compensation Act*, effective April 1, 1996, sets out the reimbursement for medical treatment.
4. 28 Texas Administrative Code §133.307, effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, sets out the procedure for medical fee dispute resolution.
5. 28 Texas Administrative Code §133.304, effective July 15, 2000, 25 TexReg 2115, requires the insurance carrier to develop and consistently apply a methodology to determine fair and reasonable reimbursement.
6. Neither party to this dispute submitted copies of explanation of benefits to support the denial of reimbursement for the disputed services.

Issues

1. Did the requestor submit this dispute in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307?
2. Did the respondent support position that the requestor has not met the requirements of 28 Texas Administrative Code §133.307(e)(2)(B)?
3. Did the respondent support position that the services were denied based upon medical necessity?
4. Is the requestor entitled to reimbursement for CPT code 97112?
5. Is the requestor entitled to reimbursement for CPT code 97530?
6. Is the requestor entitled to reimbursement for CPT code 97265?
7. Is the requestor entitled to reimbursement for CPT code 99213-MP?
8. Is the requestor entitled to reimbursement for CPT code 97250?
9. Is the requestor entitled to reimbursement for CPT code 99455?

10. Is the requestor entitled to reimbursement for CPT code 99090?

Findings

1. 28 Texas Administrative Code §133.307(e)(2)(A), requires that the request shall include "a copy of all medical bill(s) as originally submitted to the carrier for reconsideration…" Review of the documentation submitted by the requestor finds that the request does include a copy of the medical bill(s) as submitted to the carrier for reconsideration for all dates of service except June 6, 2003. The Division concludes that the requestor has not met the requirements of §133.307(e)(2)(A); therefore, reimbursement for date of service June 6, 2003 cannot be recommended.
2. The respondent states in the position summary that "…the requestor has neglected to follow the requirements of 28 TAC §133.307(e)(2) because the request does not include either the response from the Carrier to the reconsideration request or convincing proof of the Carrier's receipt of the reconsideration request."

   28 Texas Administrative Code §133.307(e)(2)(B), requires that the request shall include "a copy of each explanation of benefits (EOB)… relevant to the fee dispute or, if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB." Review of the May 11, 2004 letter from the respondent to the requestor states "Please note we are in receipt of your request for reconsideration for the attached bills. However if you will review the reply by Forte the IRO. These dates of service were not included in the decision." The Division concludes that the requestor has met the requirements of §133.307(e)(2)(B).

3. The respondent states in the supplemental position summary that "**This is a fee dispute involving retrospective medical necessity**. The carrier disputes that the provider has shown that the treatment underlying the charges were medically reasonable and necessary."

   The Division requested an IRO review to determine the medical necessity of treatment rendered from dates of service June 2, 2003 through June 6, 2003. The IRO concluded that treatment was medically necessary and further stated that "The last objective documentation from a third party is from Dr. Weber who felt the claimant was not at MMI until 06/30/2003 and she also noted that the claimant's felt his pain was only reduced while receiving care in his chiropractor's office. The claimant reported that he initially was only able to walk for 1 minute, but had since increased his walks to 25 minutes. This significant improvement in mobility justifies the care in question."

   A review of the Division's records indicates that on September 8, 2006, the Division spoke to the respondent's representative, Patsy, and requested copies of the explanation of benefits to substantiate the respondent's denial of reimbursement. On September 28, 2006, the respondent's representative, Patsy from Crawford & Co., stated that they could not locate the explanation of benefits. Therefore, the respondent has not supported the position that the disputed services were denied based upon medical necessity. The disputed services will be reviewed based upon applicable Division rules and fee guidelines.
4. CPT code 97112 is defined as "Therapeutic procedure, one or more areas, each 15 minutes, neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception". The maximum allowable reimbursement (MAR) is $35.00/15 minutes. The requestor is due reimbursement for dates of service June 10, 2003, June 12, 2003, June 13, 2003, June 16, 2003 and June 17, 2003. Therefore, 5 X $35.00 = $175.00.
5. CPT code 97530 is defined as "Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes". The MAR is $35.00/15 minutes. The requestor is due reimbursement for dates of service June 9, 2003, June 10, 2003, June 12, 2003, June 13, 2003, June 16, 2003 and June 17, 2003. Therefore, $35.00 X 3 = $105.00 X 6 = $630.00.
6. CPT code 97265 is defined as "Joint mobilization, one or more areas (peripheral or spinal)". The MAR is $43.00. The requestor is due reimbursement for dates of service June 9, 2003 and June 13, 2003. Therefore, $43.00 X 2 = $86.00.
7. CPT code 99213-MP is defined as "Office or outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity…" The MAR is $48.00. The requestor is due reimbursement for dates of service June 9, 2003, June 10, 2003, June 12, 2003, June 13, 2003, June 16, 2003 and June 17, 2003. Therefore, $48.00 X 6 = $288.00.
8. CPT code 97250 is defined as "Myofascial release/soft tissue mobilization, one or more regions. The MAR is $43.00. The requestor is due reimbursement for dates of service June 10, 2003, June 12, 2003, June 16, 2003 and June 17, 2003. Therefore, $43.00 X 4 = $172.00.
9. CPT code 99455 is defined as "Work related or medical disability examination by the treating physician that includes: completion of a medical history to commensurate with the patient's condition; performance of an examination commensurate with the patient's condition; formulation of a diagnosis, assessment of capabilities

and stability, and calculation of impairment; development of future medical treatment plan; and completion of necessary documentation/certificates and reports." The MAR is DOP.

Per Evaluation and Management Ground Rule (XXII)(A), "The reimbursement for determination of maximum medical improvement shall be the applicable established patient office visit for the level of service associated with the examination. The treating doctor shall bill using code 99455 with the modifiers L1-L5 to correspond with the last digit of the office visit codes 99211-99215. A review of the submitted medical bill finds the requestor used modifier L1. The MAR for CPT code 99211 is $18.00

Per Evaluation and Management Ground Rule (XXII)(B), "The reimbursement for the determination of an impairment rating shall be according to the areas rated as outlined in subsection (C) and (D) of this section. The treating doctor shall bill the code 99455. A review of the submitted medical bill finds the requestor used CPT code 99455.

Per Evaluation and Management Ground Rule (XXII)(C), "The HCP shall indicate the number of areas rated in the units column of the billing form with a maximum of four areas (three body areas and one specialty area). A review of the submitted medical bill finds the requestor billed for one (1) area.

Per Evaluation and Management Ground Rule (XXII)(C)(1)(b)(i), "The reimbursement is: one body area: $300.00."

Therefore, the documentation submitted supports reimbursement of $318.00 for CPT code 99455.

10. CPT code 99090 is defined as "Analysis of information data stored in computers (eg, ECGs, blood pressures, hematologic data)". The requestor did not submit a report to support billing for this service; therefore, reimbursement cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports additional reimbursement sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307 for date of service June 6, 2003. The Division further concludes that the requestor supported its position that reimbursement is due for dates of service June 10, 2003, June 12, 2003, June 16, 2003, June 17, 2003, and June 25, 2003. As a result, the amount ordered is $1669.00.
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ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1669.00 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	3/30/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.